Mattalino Orthopaedics

Angelo J. Mattalino, M.D.

2222 East Highland Ave
Phoenix, Arizona 85016
Phone: (602) 667 6640
Fax: (480) 763 1375

Patient Registration Form

Today's Date:	PCP:

PATIENT INFORMATION

Last name:	First:	Middle:

Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Date of Birth:	Age:	Sex: ○ M ○ F

Address:

Social Security #:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Other family members seen here:

How did you hear about us?

INSURANCE INFORMATION

(Please give your insurance card and photo ID to the receptionist)

Person responsible for bill:	Date of Birth:	Address (if different):	Home phone #:
Is this person a patient here?	○ Yes ○ No	Is this patient covered by insurance?	○ Yes ○ No
Occupation:	Employer:	Employer address:	Employer phone #:

Primary Insurance Name:

Subscriber's name:	Date of Birth:	Group #:	Policy #:	

Patient's relationship to subscriber:

Name of secondary insurance	Subscriber's name:	Group no #:	Policy #:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #:	Work phone #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. In the event of default, I promise to pay collection costs and reasonable fees as may be required to collect the unpaid balance on my account. I also authorize Mattalino Orthopaedics or insurance company to release any information required to process my claims.

I understand that I am responsible to know which outside facilities my insurance company utilizes for all lab work, diagnostic testing and specialist's appointments. If prior authorizations are required by my insurance for diagnostic testing and specialists' appointments, I realize that it is my responsibility to request a referral authorization from my primary care provider. Failure to do so may result in my insurance company denying payment for services and I will be responsible for the services performed.

I authorize my insurance company to pay all benefits directly to Mattalino Orthopaedics and thereby agree to the release of relevant medical information to insurance carriers.

Patient/Guardian signature _____ Date _____

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Patient Authorization Forms

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Authorization for Medical Treatment (Under 18)

This release and consent gives Mattalino Orthopaedics, permission to administer medical treatment to my child. I understand that every effort will be made to contact me. However, in case of an emergency, if I cannot be reached, I hereby give Mattalino Orthopaedics permission to act on my behalf in providing medical treatment by qualified personnel for my child in the event that such treatment is deemed necessary or advisable for my child's health, safety and welfare. I release Mattalino Orthopaedics and all medical providers from liability in acting on my behalf in this regard in rendering such medical treatment.

Patient/Guardian signature _____ Date _____

Release of Medication History Authorization

I give Mattalino Orthopaedics permission to obtain/retrieve and view my medication history. I understand that this information will be disclosed/divulged as part of my medical record release.

Patient/Guardian signature _____ Date _____

No Show / Cancellation and Surgical Coverage Responsibility Disclaimer

No show: I understand that a $25.00 fee will be charged to my account if I neglect to cancel my appointment **24 hours prior to my schedule appointment.**

Surgical Cancellation Fee: I understand that any surgical procedure must be cancelled **NO LATER than 7 calendar days prior to the Date of Surgery or an administrative charge of $100 will be assessed to my account.**

Patient/Guardian signature _____ Date _____

Acknowledgement of Notice of Privacy Practices

I acknowledge that I have read the Notice of Privacy Practices. I understand that Mattalino Orthopaedics may, at its discretion, change the terms and conditions of this notice. I understand the content of the Notice of Privacy Practices and will be provided with a copy upon my request. I give Mattalino Orthopaedics permission to leave a message on my answering machine or with the following family members regarding reports, or blood work if I am not home when they call. I consent to general treatment, medical procedures, and medications prescribed by Mattalino Orthopaedics.

_____ Copy given to patient _____ Patient declined copy

Patient/Guardian/Personal Representative signature _____ Date _____

I give permission to disclosure protected health information from my health records, including financial information to the following:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Patient/Guardian/Personal Representative signature _____ Date _____